		FOR OHF USE					

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0022905

Facility Name: JOLIET TERRACE

Address: 2236 MCDONOUGH (Number) JOLIET (City) 60436 (Zip Code)

County: WILL

Telephone Number: (84) 647-5795 **Fax #** (847) 647-5794

IDPA ID Number: 36-2883283

Date of Initial License for Current Owners: 10/01/76

Type of Ownership:

[ ]	VOLUNTARY,NON-PROFIT	[X]	PROPRIETARY	[ ]	GOVERNMENTAL
[ ]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[X]	Partnership	[ ]	County
IRS Exemption Code		[ ]	Corporation	[ ]	Other
		[ ]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2002 to 12/31/2002 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) MORRIS ESFORMES

(Title) GENERAL PARTNER

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)

(Print Name and Title) BOB KAGDA, PARTNER

(Firm Name & Address) KRUPNICK BOKOR KAGDA & BROOKS, LTD, 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124

(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number JOLIET TERRACE # 0022905 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	120	Intermediate (ICF)	120	43,800	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	120	TOTALS	120	43,800	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	40,379	796	835	42,010	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	40,379	796	835	42,010	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.91%

D. How many bed-hold days during this year were paid by Public Aid?
760 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 10/01/76

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2002 Fiscal Year: 12/31/2002

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number JOLIET TERRACE # 0022905 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	147,932	14,478	6,705	169,115		169,115		169,115			1
2	Food Purchase		145,015		145,015		145,015	(688)	144,327			2
3	Housekeeping	119,338	16,816		136,154		136,154		136,154			3
4	Laundry	55,136	9,879	1,451	66,466		66,466		66,466			4
5	Heat and Other Utilities			58,568	58,568		58,568	269	58,837			5
6	Maintenance	56,965	15,125	22,799	94,889		94,889	5,880	100,769			6
7	Other (specify):*			7,842	7,842		7,842	81	7,923			7
8	**TOTAL General Services**	379,371	201,313	97,365	678,049		678,049	5,542	683,591			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	880,095	32,977	12,484	925,556		925,556		925,556			10
10a	Therapy	31,103		3,506	34,609		34,609		34,609			10a
11	Activities	80,317	6,145	2,520	88,982		88,982		88,982			11
12	Social Services	123,280		2,544	125,824		125,824		125,824			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,114,795	39,122	27,054	1,180,971		1,180,971		1,180,971			16
	C. General Administration											
17	Administrative	75,000		338,750	413,750		413,750	(304,268)	109,482			17
18	Directors Fees											18
19	Professional Services			50,111	50,111		50,111	5,835	55,946			19
20	Dues, Fees, Subscriptions & Promotions			15,137	15,137		15,137	(8,857)	6,280			20
21	Clerical & General Office Expenses	77,700	16,838	154,287	248,825		248,825	(125,112)	123,713			21
22	Employee Benefits & Payroll Taxes			265,421	265,421		265,421	(1,460)	263,961			22
23	Inservice Training & Education			1,360	1,360		1,360	50	1,410			23
24	Travel and Seminar							52	52			24
25	Other Admin. Staff Transportation			20,001	20,001		20,001	385	20,386			25
26	Insurance-Prop.Liab.Malpractice			99,149	99,149		99,149	1,513	100,662			26
27	Other (specify):*			55,535	55,535		55,535	(50,100)	5,435			27
28	**TOTAL General Administration**	152,700	16,838	999,751	1,169,289		1,169,289	(481,962)	687,327			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,646,866	257,273	1,124,170	3,028,309		3,028,309	(476,420)	2,551,889			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number JOLIET TERRACE #0022905 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			54,021	54,021		54,021	(13,994)	40,027			30
31	Amortization of Pre-Op. & Org.			2,428	2,428		2,428		2,428			31
32	Interest			48,880	48,880		48,880	(871)	48,009			32
33	Real Estate Taxes			32,996	32,996		32,996	743	33,739			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			29,150	29,150		29,150	2,706	31,856			35
36	Other (specify):* **OFFICE RENT**			9,210	9,210		9,210	(9,210)				36
37	**TOTAL Ownership**			176,685	176,685		176,685	(20,626)	156,059			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			65,700	65,700		65,700		65,700			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			65,700	65,700		65,700		65,700			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,646,866	257,273	1,366,555	3,270,694		3,270,694	(497,046)	2,773,648			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number JOLIET TERRACE # 0022905 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(15,078)	30		9
10	Interest and Other Investment Income	(2,130)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(688)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		25		16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(40,283)	21		18
19	Entertainment		20		19
20	Contributions	(8,436)	20		20
21	Owner or Key-Man Insurance	(1,460)	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(55,535)	27		24
25	Fund Raising, Advertising and Promotional	(157)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(1,083)	20		28
29	Other-Attach Schedule SEE PAGE 5A	(23,897)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (148,747)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(348,299)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (348,299)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (497,046)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

JOLIET TERRACE

ID# 0022905

Report Period Beginning: 01/01/2002

Ending: 12/31/2002

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ 3,866	6	1
2	MARKETING SALARIES	(12,000)	21	2
3	STAFF DEVELOPMENT	(15,763)	21	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(23,897)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number JOLIET TERRACE # 0022905 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(688)	0	0	0	0	0	0	0	0	0	0	(688)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	269	0	0	0	0	0	0	0	269	5
6	Maintenance	3,866	0	1,549	465	0	0	0	0	0	0	0	5,880	6
7	Other (specify):*	0	0	81	0	0	0	0	0	0	0	0	81	7
8	**TOTAL General Services**	3,178	0	1,630	734	0	0	0	0	0	0	0	5,542	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(310,250)	5,982	0	0	0	0	0	0	0	0	(304,268)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	174	5,492	169	0	0	0	0	0	0	0	5,835	19
20	Fees, Subscriptions & Promotions	(9,676)	0	819	0	0	0	0	0	0	0	0	(8,857)	20
21	Clerical & General Office Expenses	(68,046)	5,487	(62,637)	84	0	0	0	0	0	0	0	(125,112)	21
22	Employee Benefits & Payroll Taxes	(1,460)	0	0	0	0	0	0	0	0	0	0	(1,460)	22
23	Inservice Training & Education	0	0	50	0	0	0	0	0	0	0	0	50	23
24	Travel and Seminar	0	0	52	0	0	0	0	0	0	0	0	52	24
25	Other Admin. Staff Transportation	0	306	79	0	0	0	0	0	0	0	0	385	25
26	Insurance-Prop.Liab.Malpractice	0	665	780	68	0	0	0	0	0	0	0	1,513	26
27	Other (specify):*	(55,535)	1,681	3,754	0	0	0	0	0	0	0	0	(50,100)	27
28	**TOTAL General Administration**	(134,717)	(301,937)	(45,629)	321	0	0	0	0	0	0	0	(481,962)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(131,539)	(301,937)	(43,999)	1,055	0	0	0	0	0	0	0	(476,420)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number JOLIET TERRACE # 0022905 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	(15,078)	220	294	570	0	0	0	0	0	0	0	(13,994)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,130)	0	0	1,259	0	0	0	0	0	0	0	(871)	32
33	Real Estate Taxes	0	0	0	743	0	0	0	0	0	0	0	743	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	775	1,795	136	0	0	0	0	0	0	0	2,706	35
36	Other (specify):*	0	0	0	(9,210)	0	0	0	0	0	0	0	(9,210)	36
37	**TOTAL Ownership**	(17,208)	995	2,089	(6,502)	0	0	0	0	0	0	0	(20,626)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(148,747)	(300,942)	(41,910)	(5,447)	0	0	0	0	0	0	0	(497,046)	45

Facility Name & ID Number JOLIET TERRACE # 0022905 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SCHEDULE ATTACHED		SCHEDULE ATTACHED		EKS MANAGEMENT	LINCOLNWOOD	BOOKKEEPING
				EMI ENTERPRISES	LINCOLNWOOD	MGMT CONSULT
				IME REALTY	LINCOLNWOOD	HOME OFFICE

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	MANAGEMENT FEES	$ 320,000	EMI ENTERPRISES		$	$ (320,000)	1
2	V								2
3	V								3
4	V	17	OFFICERS SALARY				9,750	9,750	4
5	V	19	ACCOUNTING FEES				174	174	5
6	V	21	OFFICE EXPENSE				5,487	5,487	6
7	V	25	TRANSPORTATION				306	306	7
8	V	26	INSURANCE				665	665	8
9	V	27	EMPLOYEE BENEFITS				1,681	1,681	9
10	V	30	DEPRECIATION				220	220	10
11	V	35	AUTO LEASE				775	775	11
12	V								12
13	V								13
14	Total			$ 320,000			$ 19,058	$ * (300,942)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number JOLIET TERRACE # 0022905 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	21	BOOKKEEPING	$ 82,080	EKS MANAGEMENT, INC.		$	$ (82,080)	15
16	V								16
17	V								17
18	V	6	PAINTING/DECORATING				1,549	1,549	18
19	V	7	SCAVENGER				81	81	19
20	V	17	CFO SALARY				5,982	5,982	20
21	V	19	PROFESSIONAL FEES				5,492	5,492	21
22	V	20	WANT ADDS/BACKGR CKS				819	819	22
23	V	21	OFFICE EXPENSE				19,443	19,443	23
24	V	23	SEMINARS				50	50	24
25	V	24	IN-STATE LOGING/MEALS				52	52	25
26	V	25	TRANSPORTATION				79	79	26
27	V	26	INSURANCE				780	780	27
28	V	27	EMPLOYEE BENEFITS				3,754	3,754	28
29	V	30	DEPRECIATION				294	294	29
30	V	35	EQUIPMENT RENT				1,795	1,795	30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 82,080			$ 40,170	$ * (41,910)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number JOLIET TERRACE # 0022905 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	36	OFFICE RENT	$ 9,210	IME REALTY CORP.		$	$ (9,210)	15
16	V								16
17	V								17
18	V	5	UTILITIES				269	269	18
19	V	6	REPAIR & MAINTENANCE				465	465	19
20	V	19	PROFESSIONAL FEES				169	169	20
21	V	21	OFFICE EXPENSE				84	84	21
22	V	26	INSURANCE				68	68	22
23	V	30	DEPRECIATION				570	570	23
24	V	32	INTEREST				1,259	1,259	24
25	V	33	RE TAX				743	743	25
26	V	35	STORAGE FEES				136	136	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 9,210			$ 3,763	$ * (5,447)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number JOLIET TERRACE # 0022905 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	BERNARD COHEN	GENERAL PARTNE	ADMINISTRATION					MGMT FEE	$ 18,750	17-3	1
2	MORRIS ESFORMES	GENERAL PARTNE	ADMINISTRATION		SCHEDULE ATTACHED			SALARY	9,750	17-7	2
3	AVRUM WEINFELD	CFO						SALARY	5,982	17-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 34,482		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number JOLIET TERRACE # 0022905 Report Period Beginning: 01/01/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: EMI ENTERPRISES
Street Address: 6865 N LINCOLN
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847) 674-1946
Fax Number: (847) 674-1962

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	OFFICERS SALARY	PATIENT DAYS	797,100	13	$ 185,000	$ 185,000	42,010	$ 9,750	1
2	19	ACCOUNTING FEES	PATIENT DAYS	797,100	13	3,299		42,010	174	2
3	21	OFFICE EXPENSE	PATIENT DAYS	797,100	13	104,106	76,720	42,010	5,487	3
4	25	TRANSPORTATION	PATIENT DAYS	797,100	13	5,805		42,010	306	4
5	26	INSURANCE	PATIENT DAYS	797,100	13	12,620		42,010	665	5
6	27	EMPLOYEE BENEFITS	PATIENT DAYS	797,100	13	31,900		42,010	1,681	6
7	30	DEPRECIATION	PATIENT DAYS	797,100	13	4,180		42,010	220	7
8	35	AUTO LEASE	PATIENT DAYS	797,100	13	14,702		42,010	775	8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 361,612	$ 261,720		$ 19,058	25

Facility Name & ID Number JOLIET TERRACE # 0022905 Report Period Beginning: 01/01/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: EKS MGMT.
Street Address: 6865 N LINCOLN
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847) 674-1946
Fax Number: (847) 674-1962

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	PAINTING/DECORATING	PATIENT DAYS	797,100	13	$ 29,397	$ 29,397	42,010	$ 1,549	1
2	7	SCAVENGER	PATIENT DAYS	797,100	13	1,544		42,010	81	2
3	17	CFO SALARY	PATIENT DAYS	797,100	13	113,499	113,499	42,010	5,982	3
4	19	PROFESSIONAL FEES	PATIENT DAYS	797,100	13	104,205	93,812	42,010	5,492	4
5	20	WANT ADDS/BACKGR CKS	PATIENT DAYS	797,100	13	15,548		42,010	819	5
6	21	OFFICE EXPENSE	PATIENT DAYS	797,100	13	368,910	256,444	42,010	19,443	6
7	23	SEMINARS	PATIENT DAYS	797,100	13	940		42,010	50	7
8	24	IN-STATE LOGING/MEALS	PATIENT DAYS	797,100	13	994		42,010	52	8
9	25	TRANSPORTATION	PATIENT DAYS	797,100	13	1,506		42,010	79	9
10	26	INSURANCE	PATIENT DAYS	797,100	13	14,803		42,010	780	10
11	27	EMPLOYEE BENEFITS	PATIENT DAYS	797,100	13	71,229		42,010	3,754	11
12	30	DEPRECIATION	PATIENT DAYS	797,100	13	5,592		42,010	294	12
13	35	EQUIPMENT RENT	PATIENT DAYS	797,100	13	34,056		42,010	1,795	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 762,223	$ 493,152		$ 40,170	25

Facility Name & ID Number JOLIET TERRACE # 0022905 Report Period Beginning: 01/01/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: IME REALTY CORP.
Street Address: 3737 W. ARTHUR
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847) 674-1946
Fax Number: (847) 674-1962

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	RENTAL INCOME	268,762	13+FACIL	$ 7,839	$	9,210	$ 269	1
2	6	REPAIR & MAINTENANCE	RENTAL INCOME	268,762	13+FACIL	13,572		9,210	465	2
3	19	PROFESSIONAL FEES	RENTAL INCOME	268,762	13+FACIL	4,925		9,210	169	3
4	21	OFFICE EXPENSE	RENTAL INCOME	268,762	13+FACIL	2,448		9,210	84	4
5	26	INSURANCE	RENTAL INCOME	268,762	13+FACIL	1,978		9,210	68	5
6	30	DEPRECIATION	RENTAL INCOME	268,762	13+FACIL	16,647		9,210	570	6
7	32	INTEREST	RENTAL INCOME	268,762	13+FACIL	36,747		9,210	1,259	7
8	33	RE TAX	RENTAL INCOME	268,762	13+FACIL	21,685		9,210	743	8
9	35	STORAGE FEES	RENTAL INCOME	268,762	13+FACIL	3,962		9,210	136	9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 109,803	$		$ 3,763	25

Facility Name & ID Number JOLIET TERRACE # 0022905 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	SOUTH TRUST		X	MORTGAGE	$5,173.00	08/01//95	$ 1,795,000	$ 1,108,011	07/31/15		$ 39,618	1
2												2
3												3
4												4
5												5
	Working Capital											
6	LASALLE BANK		X	LINE OF CREDIT				217,000			9,262	6
7												7
8	RELATED PARTY	X									1,259	8
9	TOTAL Facility Related				$5,173.00		$ 1,795,000	$ 1,325,011			$ 50,139	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 1,795,000	$ 1,325,011			$ 50,139	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number JOLIET TERRACE # 0022905 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 31,100	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 31,896	2
3. Under or (over) accrual (line 2 minus line 1).		$ 796	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 32,200	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ _____ For _____ Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 32,996	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1997	32,600	8
	1998	32,235	9
	1999	31,203	10
	2000	30,783	11
	2001	31,896	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2001 TAX BILL.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME JOLIET TERRACE COUNTY WILL

FACILITY IDPH LICENSE NUMBER 0022905

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	30-07-18-300-016-0000	NURSING HOME	$ 31,896.04	$ 31,896.04
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 31,896.04	$ 31,896.04

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

Facility Name & ID Number JOLIET TERRACE # 0022905 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 26,836 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories _____

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME		1976	$ 100,000	1
2					2
3	TOTALS			$ 100,000	3

Facility Name & ID Number JOLIET TERRACE # 0022905 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	120		1976	1976	$ 1,233,000	$	25	$	$	$ 1,233,000	4
5											5
6											6
7											7
8	RELATED PARTY					570		570			8
	Improvement Type**										
9	BUILDING IMPROVEMENTS			1979	3,802		10			3,802	9
10	BUILDING IMPROVEMENTS			1980	10,532		3			10,532	10
11	BUILDING IMPROVEMENTS			1980	7,500		10			7,500	11
12	BUILDING IMPROVEMENTS			1982	54,503	1,730	31.5	1,730		24,148	12
13	BUILDING IMPROVEMENTS			1983	2,495		10			2,495	13
14	BUILDING IMPROVEMENTS			1989	8,100	540	15	540		7,020	14
15	BUILDING IMPROVEMENTS			1990	19,140	608	20	957	349	11,006	15
16	BUILDING IMPROVEMENTS			1991	5,335	169	20	267	98	2,803	16
17	BUILDING IMPROVEMENTS			1992	17,257	548	31.5	548		5,252	17
18	BUILDING IMPROVEMENTS			1992	11,861	377	15	377		7,100	18
19	BUILDING IMPROVEMENTS			1993	4,065	129	31.5	129		1,137	19
20	BUILDING IMPROVEMENTS			1993	14,238	366	39	366		3,079	20
21	BUILDING IMPROVEMENTS			1994	5,200	133	39	133		937	21
22	FLOORING INSTALL			1995	9,823	252	39	252		1,237	22
23	ROOFING			1995	12,675	325	39	325		1,502	23
24	TILES			1996	15,503	398	39	398		1,837	24
25	FLOOR TILES			1998	23,132	593	39	593		2,082	25
26	ROOFING			1999	17,100	438	39	438		1,224	26
27	BLINDS/WALLCOVERING/WINDOW TREATMENTS			2000	19,897	3,480	20	995	(2,485)	2,487	27
28	COVE BASE			2000	2,679	98	27.5	98		272	28
29	SPRIKLER HEADS			2000	4,300	156	27.5	156		345	29
30	AIR CONDITIONS			2001	1,887	69	27.5	69		100	30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number JOLIET TERRACE # 0022905 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,504,024	$ 10,979		$ 8,941	$ (2,038)	$ 1,330,897	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number JOLIET TERRACE # 0022905 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 295,534	$ 33,488	$ 29,421	$ (4,067)	10	$ 139,282	71
72	Current Year Purchases	23,011	10,124	1,151	(8,973)	10	1,151	72
73	Fully Depreciated Assets	314,059					314,059	73
74	RELATED PARTY		514	514				74
75	TOTALS	$ 632,604	$ 44,126	$ 31,086	$ (13,040)		$ 454,492	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 2,236,628	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 55,105	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 40,027	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (15,078)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,785,389	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number JOLIET TERRACE # 0022905 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 18,137 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	ACTIVITY & MAINT.	2001 CHEVY VAN	$ 699.00	$ 10,547	17
18	FACILITY		466.00	466	18
19					19
20					20
21	TOTAL		$ 1,165.00	$ 11,013	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number JOLIET TERRACE # 0022905 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number JOLIET TERRACE # 0022905 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care	N/A	visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number JOLIET TERRACE # 0022905 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2002 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 150,720	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 55,535)	753,823		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	67,901		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	625,875		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,598,319	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable	37,657		11
12	Long-Term Investments			12
13	Land	100,000		13
14	Buildings, at Historical Cost	1,233,000		14
15	Leasehold Improvements, at Historical Cost	271,024		15
16	Equipment, at Historical Cost	632,604		16
17	Accumulated Depreciation (book methods)	(1,894,324)		17
18	Deferred Charges	30,587		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 410,548	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,008,867	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 118,545	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	217,000		29
30	Accrued Salaries Payable	56,112		30
31	Accrued Taxes Payable (excluding real estate taxes)	21,939		31
32	Accrued Real Estate Taxes(Sch.IX-B)	32,200		32
33	Accrued Interest Payable	772		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 446,568	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,108,011		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,108,011	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,554,579	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 454,288	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,008,867	$	48

*(See instructions.)

Facility Name & ID Number JOLIET TERRACE # 0022905 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 456,894	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 456,894	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	33,477	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(36,083)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (2,606)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 454,288	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number JOLIET TERRACE # 0022905 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,302,041	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,302,041	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,130	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 2,130	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,304,171	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	678,049	31
32	Health Care	1,180,971	32
33	General Administration	1,169,289	33
	B. Capital Expense		
34	Ownership	176,685	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	65,700	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,270,694	40
41	**Income before Income Taxes (line 30 minus line 40)****	33,477	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 33,477	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number JOLIET TERRACE # 0022905 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,059	2,111	$ 58,159	$ 27.55	1
2	Assistant Director of Nursing					2
3	Registered Nurses	530	530	10,783	20.35	3
4	Licensed Practical Nurses	14,584	14,980	281,018	18.76	4
5	Nurse Aides & Orderlies	46,864	48,494	434,400	8.96	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,047	3,387	31,103	9.18	8
9	Activity Director					9
10	Activity Assistants	8,979	9,359	80,317	8.58	10
11	Social Service Workers	10,130	10,633	123,280	11.59	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	16,388	17,390	147,932	8.51	15
16	Dishwashers					16
17	Maintenance Workers	5,320	5,507	56,965	10.34	17
18	Housekeepers	14,293	15,465	119,338	7.72	18
19	Laundry	6,863	7,506	55,136	7.35	19
20	Administrator	2,080	2,080	75,000	36.06	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,117	9,456	77,700	8.22	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,975	2,124	40,535	19.08	31
32	Other Health C: WARD CLERK	1,404	1,520	16,144	10.62	32
33	Other(specify) QUALITY ASSUR	1,996	2,176	39,056	17.95	33
34	TOTAL (lines 1 - 33)	145,629	152,718	$ 1,646,866 *	$ 10.78	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	M	$ 6,705	1-3	35
36	Medical Director	O	6,000	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	5,640	10-3	39
40	Physical Therapy Consultant	L	1,377	10a-3	40
41	Occupational Therapy Consultant	Y	2,129	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	2,520	11-3	44
45	Social Service Consultant	E	2,544	12-3	45
46	Other(specify) PSYCHO-SOCIAL	S	2,352	10-3	46
47	DENTAL		3,025	10-3	47
48					48
49	TOTAL (lines 35 - 48)		$ 32,292		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$	10-3	50
51	Licensed Practical Nurses			10-3	51
52	Nurse Aides	5	47	10-3	52
53	TOTAL (lines 50 - 52)	5	$ 47		53

Facility Name & ID Number JOLIET TERRACE # 0022905 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
JANET CANTELO	ADMIN	0	$ 75,000
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 75,000

B. Administrative - Other

Description	Amount
EMI ENTERPRISES	$ 320,000
BERNARD COHEN	18,750
TOTAL (agree to Schedule V, line 17, col. 3)	$ 338,750
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
ALPHA DATA SYSTEM	DATA PROCESSING	$ 3,438
MAXX SOURCE	DATA PROCESSING	1,250
NURSING CARE	DATA PROCESSING	5,457
LTC SOLUTIONS	DATA PROCESSING	1,320
KRUPNICK, BOKOR, KAGDA	ACCOUNTING	16,400
McBRIDE BAKER	LEGAL	2,815
LAWRENCE SCHWARTZ	LEGAL	9,000
PROFESSIONAL ASSOC.	ALTA SURVEY	3,000
LINCOLWOOD FUNDING	REMARKETING	3,502
PRO CLAIM AMERICA	INSURANCE. ASSESMT	2,602
PERSONNEL PLANNERS	UC CONSULTANT	1,327
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 50,111

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 57,483
Unemployment Compensation Insurance	32,813
FICA Taxes	125,986
Employee Health Insurance	36,766
Employee Meals	#REF!
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	3,121
EMPLOYEE PHYSICAL EXAMS	0
PENSION/PROFIT SHARING PLANS	7,792
CHICAGO HEAD TAX	0
INSURANCE - EXECUTIVE LIFE	1,460
INSURANCE - EXECUTIVE LIFE VI 21	(1,460)
TOTAL (agree to Schedule V, line 22, col.8)	$ #REF!

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	934
Health Care Worker Background Check	20
(Indicate # of checks performed)	
MARKETING/ADV/PROMO	1,240
TRUST/FRANCHISE/CONTRIB/ETC	8,436
LICENSES & PERMITS	655
DUES & SUBSCRIPTIONS	3,652
MGMT CO ALLOCATION	819
TRUST/FRANCHISE/CONTRIB/ETC	(8,436)
Less: Public Relations Expense	(0)
Non-allowable advertising	(157)
Yellow page advertising	(1,083)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 6,280

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
RELATED PARTY	52
Seminar Expense	
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 52

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number JOLIET TERRACE # 0022905 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	PAINTING/DECORATIN	1999	$ 22,346	3	$ 3,724	$ 7,449	$ 7,449	$ 3,724	$	$	$	$	$
2	PAINTING/DECORATIN	2001	424	3			70	142	142	70			
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 22,770		$ 3,724	$ 7,449	$ 7,519	$ 3,866	$ 142	$ 70	$	$	$

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL COUNCIL ON LONG TERM $3102**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **0** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **65,700**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **#REF!** Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ N/A

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.

Facility Name & ID#: JOLIET TERRACE **#0022905** **Report Period Beginning: 01/01/2002** **Ending: 12/31/2002**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	6,705	
	REPAIRS & MAINTENANCE		0	
			0	6,705
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		1,451	
			0	1,451
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		23,941	
	ELECTRICITY		27,525	
	WATER		7,102	
	CABLE TV - LOBBY		0	
			0	58,568
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		5,020	
	PAINTING & DECORATING		424	
	BUILDING REPAIRS		7,904	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		5,333	
	ELEVATOR MAINTENANCE & REPAIR		0	
	OUTSIDE LABOR		360	
	EXTERMINATING SERVICE		1,156	
	FIRE SERVICE		2,602	
			0	
			0	
			0	22,799
7	**OTHER**			
	SCAVENGER		6,418	
	SECURITY SERVICE		1,424	7,842
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	6,000	6,000

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2	47	
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		1,420	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	2,352	
	RESTORATIVE NURSING CONSULTAN	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	0	
	PHARMACY CONSULTANT	XVIII B 39-2	5,640	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	0	
	DENTAL		3,025	
			0	12,484
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		0	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	1,377	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	2,129	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	3,506
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	2,520	
			0	2,520
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	2,544	
	SOCIAL WORKER	XVIII B 45-2	0	
			0	2,544
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number JOLIET TERRACE **#0022905** **Report Period Beginning: 01/01/2002** **Ending: 12/31/2002**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		0	0
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	338,750	338,750
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	11,465	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	38,646	
			0	50,111
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	157	
	EMPLOYEE WANT ADS	XIX F	934	
	CONTRIBUTIONS	VI 20 XIX F	150	
	DUES & SUBSCRIPTIONS	XIX F	3,652	
	LICENSES & PERMITS	XIX F	855	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	1,083	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	8,286	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	20	15,137
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		370	
	EQUIPMENT REPAIR & MAINTENANCE		2,986	
	OUTSIDE CLERICAL SERVICES		82,080	
	PENALTIES / OVERDRAFT CHARGES	VI 18	40,283	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		12,805	
	MESSENGER SERVICE		0	
	STAFF DEVELOPMENT		15,763	154,287

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	125,986	
	UNEMPLOYMENT COMPENSATION	XIX D	32,813	
	WORKERS COMPENSATION INSURANC	XIX D	57,483	
	HOSPITALIZATION INSURANCE	XIX D	36,766	
	EMPLOYEE BENEFITS - OTHER	XIX D	3,121	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	1,460	
	PENSION/PROFIT SHARING PLANS	XIX D	7,792	
	CHICAGO HEAD TAX	XIX D	0	265,421
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		1,360	1,360
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	0	
			0	
			0	0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		20,001	20,001
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		99,149	99,149
27	**OTHER**			
	BAD DEBTS	VI 24	55,535	
			0	55,535

GRAND TOTAL COLUMN 3 OTHER 1,124,170